Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration &
Division of Developmental Disabilities

Private Duty Nursing for Children

Billing Instructions

[WAC 388-551-3000]

About this publication

This publication supersedes all previous MAA Private Duty Nursing Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Table of Contents

Important Contacts

A provider may use MAA's toll-free lines for questions regarding MAA programs, however MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)]

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment
Toll-Free: (866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9246
Olympia WA 98507-9245

Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

Go to MAA's website at:
http://maa.dshs.wa.gov
Click on "Provider Publications/Fee Schedules."

Who do I call for prior authorization?

Division of Developmental Disabilities
Medically Intensive Home Care Program
Nurse Coordinator
(360) 902-8469

Where do I call if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Medical Assistance Customer Service Ctr
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Internet billing?

Go to: http://maa.dshs.wa.gov/ecs

Pharmacy Authorization?

(800) 848-2842

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Authorization –Official approval for action taken for, or on behalf of, an eligible client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A number assigned by Medical Assistance Administration (MAA) that identifies a specific request for approval for services or equipment. [WAC 388-500-0005]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) - Rules adopted by the federal government [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Division of Developmental Disabilities – The organization within DSHS that supports individuals enrolled in DDD per RCW 71A.10.020 (3) and (4), and WAC 388-825-030

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. [WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence. [WAC 388-500-0005]

Intermittent Home Health – Skilled nursing services and specialized therapies provided in a client's residence. Services are for client's with acute, short-term intensive courses of treatment.

Managed Care – A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-500-0005]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid – The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program

Medical Assistance Administration (MAA) – The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities. [WAC 388-500-0005]

Medical Identification Card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as MAID cards. [WAC 388-500-0005]

Medically Intensive Home Care Program – A program managed by DDD that provides a home-based program for clients age 17 and under who require complex, long-term care for a condition of such severity and/or complexity that continuous skilled nursing care is required. Persons with medically intensive needs require more individual and continuous care than is available from an intermittent visiting nurse.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

[WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Plan of Treatment (POT) – (Also known as "plan of care" [POC]) The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Provider Number – an identification number issued to providers who have a signed contract(s) with MAA.
[WAC 388-500-0005]

Remittance And Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.
[WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State laws.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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Private Duty Nursing Services

Private duty nursing services are administered by the Division of Developmental Disabilities (DDD) through the Medically Intensive Home Care Program (MIHCP). The purpose of this program is to reduce the cost of health care services by providing equally effective, more conservative, and/or less costly treatment in a client's home.

Private duty nursing services are considered *supportive* to the care provided to the client by family members or guardians. Private duty nursing services are decreased as the family/ guardian or other caregiver becomes able to meet the client's needs or when the client's needs diminish.

What are private duty nursing services?

[Refer to WAC 388-551-3000]

Private duty nursing services consists of four or more hours of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services.

Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

- **Assessments** (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);

- **Administration of treatment related to technological dependence** (e.g., ventilator, tracheotomy, BIPAP (bilevel positive airway pressure), IV (intravenous) administration of medications and fluids, feeding pumps, nasal stints, central lines);

- **Monitoring and maintaining parameters/machinery** (e.g., oximetry, blood pressure, lab draws, end tidal CO_2s, ventilator settings, humidification systems, fluid balance, etc.); and

- **Interventions** (e.g., medications, suctioning, IVs, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

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Client Eligibility

Who is eligible for private duty nursing services for children? [Refer to WAC 388-551-3000(2)]

To be eligible for private duty nursing services, a client must meet all of the following:

- Be 17 years of age or younger;
  [For clients over 18 years of age or older who require private duty nursing, contact Aging and Adult Services at (360) 493-4512.]

- Need continuous skilled nursing care that can be provided safely outside an institution;

- Have prior authorization from the department; and

- Present a Medical ID card listing one of the following identifiers:

Medical ID Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	Children's Health Insurance Program
LCP-MNP	Limited Casualty Program – Medically Needy Program

Are clients who are enrolled in an MAA managed care plan eligible for private duty nursing services?

Private duty nursing services are included in the scope of service under MAA's managed care plans. Clients with an identifier in the HMO column on their Medical ID cards are enrolled in one of MAA's managed care plans and must receive all private duty nursing services directly through their plan. Clients can contact their plan by calling the telephone number indicated on their Medical ID card.

Primary Care Case Manager/Management:

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their service via the PCCM. The PCCM is responsible for coordination of care just like the primary care provider (PCP) would be in a managed care plan. Please refer to the client's Medical ID card for the PCCM.

Women enrolled in the PCCM model of Healthy Options must have a referral from their PCP in order for women's health care services to be paid to an outside provider. The reason for this is the Indian clinics that contract as PCCMs do not meet the definition of health carriers in chapter 48.42 RCW. These clinics are not any of the organizations listed in Section 1 of this RCW; thus, they are exempt from the requirements spelled out in this act, including self-referrals by women to women's health care services.

Provider/Client Responsibilities

Who must perform the private duty nursing services?

[Refer to WAC 388-551-3000(3)]

The Department of Social and Health Services (DSHS) contracts only with home health agencies licensed by Washington state to provide private duty nursing services. The licensed home health agency must also be enrolled with the Medical Assistance Administration (MAA) as a medical provider. (See *Important Contacts* section for telephone number for Provider Enrollment.)

Within the home health agency, Private Duty Nursing services must be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the direction of a physician. [WAC 388-551-3000(5)(e)]

Appropriate medical training for the nurses and the family/guardian is the responsibility of the discharging hospital and the receiving licensed home health agency. Training costs due to nurse turnover or client transfers are the responsibility of the licensed home health agency.

The licensed home health agency is responsible for meeting all of the client's nursing needs. MAA will not approve intermittent nursing visits in addition to Private Duty Nursing services.

Who's responsible for choosing a private duty nursing agency?

Choosing a licensed home health agency is the responsibility of one, or a combination, of the following caregivers involved with the client's care:

- Family member/guardian;
- Attending physician;
- Client's social worker or case manager; or
- Discharge planner.

See "How do I request prior authorization?" on page D.1.

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Prior Authorization

Is prior authorization required for private duty nursing services? [Refer to WAC 388-551-3000(4)]

Yes! Providers must receive prior authorization from the Division of Developmental Disabilities (DDD) **prior** to providing private duty nursing services to clients.
DSHS approves requests for private duty nursing services on a case-by-case basis.

How do I request prior authorization?

[Refer to WAC 388-551-3000(4)]

A provider must coordinate with a Division of Developmental Disability case manager and request prior authorization by submitting a complete referral to the Division of Developmental Disabilities.

This referral must include all of the following:

- The client's age, medical history, diagnosis, and current prescribed treatment plan as developed by the individual's physician;
- Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;
- An emergency medical plan which includes notification of electric, gas, and telephone companies, as well as local fire department;
- A written request from the client or the client's legally authorized representative for home care; and
- Psycho-social history/summary which provides the following information:
  - ✓ Family constellation and current situation;
  - ✓ Available personal support systems;
  - ✓ Presence of other stresses within and upon the family; and
  - ✓ Projected number of nursing hours needed in the home, after discussion with the family or guardian.

Where do I send the completed referral?

MIHCP Nurse Coordinator
Division of Developmental Disabilities
PO Box 45310
Olympia WA 98504-5310

When does DSHS approve requests for private duty nursing services? [Refer to WAC 388-511-3000(5)]

DSHS approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

- The information submitted by the provider is complete;
- The care will be provided in the client's home;
- The cost of private duty nursing does not exceed the cost to the department for institutional care;
- An adult family member or guardian has been trained and is capable of providing the skilled nursing care;
- A registered or licensed practical nurse will provide the care under the direction of a physician; and
- Based on the referral submitted by the provider, DSHS determines:
  - ✓ The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;
  - ✓ The client requires more nursing care than is available through the home health services program; and
  - ✓ The home care plan is safe for the client.

Coverage

What is covered? [Refer to WAC 388-551-3000(6)]

Upon approval, the MIHCP nurse coordinator will notify the client's DDD case manager of the final determination. The MIHCP nurse coordinator will authorize private duty nursing services **up to a maximum of 16 hours per day** (see **exception** listed below), restricted to the least costly, equally effective amount of care.

Exception: The MIHCP nurse coordinator may authorize additional hours for a maximum of 30 days, if any of the following apply:

- ✓ The family or guardian is being trained in care and procedures;
- ✓ There is an acute episode that would otherwise require hospitalization and the treating physician determines that noninstitutional care is still safe for the client;
- ✓ The family or guardian caregiver is ill or temporarily unable to provide care;
- ✓ There is a family emergency; or
- ✓ The department determines it is medically necessary.

The client's DDD case manager will notify the client's caregivers. Once the specific nursing agency is selected and prior to the initiation of care, that agency must contact the MIHCP nurse coordinator to obtain the authorization number and the number of nursing care hours allowed for each MIHCP client.

Before starting the care, call:
MIHCP Nurse Coordinator
(360) 902-8469

It is the nursing agency's responsibility to contact the MIHCP nursing coordinator to obtain an authorization number and verify the total number of hours authorized at the beginning of each approved time span. Additional nursing hours beyond the allotted monthly hours must be prior authorized.

The MIHCP nurse coordinator will adjust the number of authorized hours when the client's condition or situation changes. Any hours of nursing care services in excess of those authorized by the MIHCP nurse coordinator must be provided by a trained, adult family member or guardian, or paid for by the client, family or guardian.

The nursing notes and plan of care must be kept in the client's file and made available for review by the MIHCP Nurse Coordinator upon request.

The plan of care must be updated every 62 days to include:

- ✓ Physician assessment;
- ✓ Current orders;
- ✓ Current signature;
- ✓ Current nursing assessment;
- ✓ Current nursing care plan;
- ✓ Nursing notes for past week; and
- ✓ Medical necessity for current nursing hours.

Billing

Scheduling of Hours

RN service hours may be performed in combination with LPN service hours. The combination must not exceed the total hours that have been prior approved for each calendar month of care.

Multiple Clients in the Same Home

Upon authorization, the MIHCP Nurse Coordinator may assign special procedure codes. These procedure codes will be used when the private duty nurse cares for more than one client in the same home. Be sure to use a separate HCFA-1500 claim form for each client receiving private duty nursing services.

Services Covering More Than One Month

If you receive prior authorization from the MIHCP Nurse Coordinator to provide more than one month of services, bill each month on a separate line (see item 24A in *Instructions for Completing the HCFA-1500 Claim Form*).

What is the time limit for billing? **[Refer to WAC 388-502-0150]**

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

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1 **Delayed Certification:** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month – If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible form the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and the bill MAA for the service.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note:	MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

2 **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s) in field 17a. If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

What records must be kept? **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.

The Private Duty Nursing for Children Fee Schedule (previously found on pages F.4) is now located in the appendix. To view or download the Fee Schedule, click Appendix.

How to Complete the HCFA-1500 Claim Form

Important! **Guidelines/Instructions:**

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferable on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA 1500 claim forms.

- **Do not use red ink pens (use black ink for the circle "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," OR "SECOND SUBMISSION" on the claim form.

- **Use standard typewritten fonts** that are 10 c.p.i. (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form.** MAA does not accept "continued" claim forms. If more than six detail lines are needed, used additional claim forms.

- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical ID card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify twin A or B, triplet A, B, or C here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: Required. Enter the 9-digit number assigned for the specific dates of service. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 8, 2003 = 100803).

24B. **Place of Service**: Required. Enter the following code:

Code Number	To Be Used For
12	Home

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of hours (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provide

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

PRIVATE DUTY NURSING

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JA120391JONESA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JONES JENNIFER A

3. PATIENT'S BIRTH DATE MM 12 DD 03 YY 91 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5560 SHINGLE STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 853.0 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	15	03	12		T1000	TD	853.0	120200	160				
2	10	01	03	10	15	03	12		T1000	TE	853.0	57950	100				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 178150

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 178150

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CARE PLUS NURSING 110 MAIN STREET
ANYTOWN WA 98000

PIN# GRP# 9000350

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Health & Recovery Services Administration (HRSA)
Private Duty Nursing Fee Schedule
Effective July 1, 2006

Code Status Indicator	Billing Code	Modifiers			Comments	Maxamum Allowable Rate	EPA/PA
R	T1000	TD			RN, per 15 min	$8.03	
R	T1000	TD	TU		RN, per 15 min, overtime	$10.84	
R	T1000	TD	TV		RN, per 15 min, holiday*	$10.84	
R	T1000	TD	TK		RN-second client; same home, per 15 min.	$4.01	
R	T1000	TD	TK	TV	RN-second client; same home, per 15 min., holiday*	$5.41	
R	T1000	TE			LPN, per 15 min.	$6.19	
R	T1000	TE	TU		LPN, per 15 min. overtime	$8.35	
R	T1000	TE	TV		LPN, per 15 min., holiday	$8.35	
R	T1000	TE	TK		LPN - second client; same home, per 15 min.	$3.09	
R	T1000	TE	TK	TV	LPN - second client; same home, per 15 min., holiday	$4.18	

Modifiers In This Fee Schedule
TD = RN
TE = LPN
TV = Holiday
TK = Second client
TU = Overtime

Status Indictors
D = Discontinued Code
N = New Code
P = Policy Change
R = Rate Update